Michigan Department of Community Health Children's Special Health Care Services

NOTICE OF ACTION

Client's Name: (Last, First, Middle)		
Date of Birth	CSHCS/Medicaid I.D.	Client's County:
INFORMATION:		
Add Provider (Include Medicaid Provider I.D. Number, Specialty and for what diagnosis the provider is needed.)		
Out of State Medical Request	Name Change	Address Change
☐ New Phone NumberComments / Description:	Questions	Other
Signature Request Date RESPONSE:		
Signature		Date of Response
Signature		Date of Response

AUTHORITY: Act 368, P.A. 1978.

COMPLETION: Is Voluntary, but required if CSHCS program

services are desired.

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.